ADMISSION TO SERVICE AND ANSWER TO APPLICATION

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

You are the **RESPONDENT** in this matter.

Complete all blanks. Type or print legibly.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

WC Claim Number	Employee Name
Employee Social Security Number	Employer Name
Date of Alleged Injury	Employer Mailing Address (Number, Street, City, State, Zip Code)
Insurance Company Name	Insurance Company Mailing Address (Number, Street, City, State, Zip Code)
Respondent Attorney Name	Respondent Attorney Mailing Address (Number, Street, City, State, Zip Code)

Enclosed is a copy of a hearing application filed with this office. The applicant charges that compensation or medical expense due for an alleged injury has not been properly paid. This application for worker's compensation benefits must be answered by you within 20 days. One copy of the answer should be mailed to the Worker's Compensation Division and one copy to the applicant or his/her attorney. Provide such responses as are now known and amend your responses later as necessary.

If you accept liability for payment of compensation to the applicant, you should immediately pay that compensation which is due. This will save you and the applicant the expense of a hearing.

If you concede that a portion of the claimed benefits is due and accrued, you should promptly make payment of those conceded amounts. You do not withhold payment because an application has been filed.

It is the duty of the worker's compensation insurer to file the answer on behalf of the employer. The only exceptions are applications for 15% increased compensation due to the failure on the part of the employer to furnish a safe place and methods of employment or for wages lost due to unreasonable failure to rehire following a compensable injury. These must be answered by the employer.

Failure by the employer or insurer to file a timely answer may result in liability pursuant to a default order.

In answer to the application, the respondent states:

1. The accident or occupational exposure alleged in the application actually occurred on or about the time claimed ☐ Admitted ☐ Denied
2. The relationship of employer and employee existed ☐ Admitted ☐ Denied
3. The parties were subject to the worker's compensation act ☐ Admitted ☐ Denied
4. At the time of alleged injury, the employee was performing service growing out of and incidental to employment ☐ Admitted ☐ Denied
5. The accident or disease causing injury arose out of the alleged employment ☐ Admitted ☐ Denied
6. Notice of injury was given to employer within 30 days/2 years of alleged injury ☐ Admitted ☐ Denied
7. Applicant was temporarily disabled for the period claimed ☐ Admitted ☐ Denied
   If denied, state disability admitted: _____
8. Applicant is permanently disabled to the extent claimed ☐ Admitted ☐ Denied
   If denied, state disability admitted: _____
9. The rate of wage claimed is correct ☐ Admitted ☐ Denied
   If denied, state wage admitted: _____
10. The alleged employer was insured under the worker's compensation act ☐ Admitted ☐ Denied
11. State exactly what matters are in dispute and your reason for denying liability.
    Use reverse side, if necessary. (If any statements are found to be incorrect, you may file an amended answer.)

BE CERTAIN TO PROVIDE THE INFORMATION REQUESTED BELOW:

Amount of compensation paid to date or current WKC-13 showing all payment	Respondent Signature Representing: ☐ Employer ☐ Insurance Co. Phone: (_____)_____	Date Signed